

# **FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

## **Preamble**

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- ❖ Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- ❖ Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- ❖ Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- ❖ Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR THE ANNUAL REPORT OF  
THE STATE CHILDREN'S HEALTH INSURANCE PLANS  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

State/Territory: State of Washington  
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

\_\_\_\_\_  
(Signature of Agency Head)

SCHIP Program Name(s): Children's Health Insurance Program (CHIP)

SCHIP Program Type:

☐ SCHIP Medicaid Expansion Only  
☒ Separate Child Health Program Only  
☐ Combination of the above

Reporting Period: Federal Fiscal Year 2002 *Note: Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02.*

Contact Person/Title: Diane Kessel, Children's Health Insurance Program Manager

Address: Medical Assistance Administration, PO Box 45536, Olympia, WA 98504-5536

Phone: ( 360) 725-1715 Fax: ( 360) 586-2388

Email: Kessedc@dshs.wa.gov

Submission Date: January 10, 2003

*(Due to your CMS Regional Contact and Central Office Project Officer by January 1<sup>st</sup> of each year)  
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)*

## SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

- 1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility	From		% of FPL for infants		% of FPL	From	Over 200%	% of FPL for infants	Less than 250%	% of FPL
	From		% of FPL for children ages 1 through 5		% of FPL	From	Over 200%	% of FPL for children ages 1 through 5	Less than 250%	% of FPL
	From		% of FPL for children ages 6 through 16		% of FPL	From	Over 200%	% of FPL for children ages 6 through 16	Less than 250%	% of FPL
	From		% of FPL for children ages 17 and 18		% of FPL	From	Over 200%	% of FPL for children ages 17 and 18	Less than 250%	% of FPL
Is presumptive eligibility provided for children?		No				X	No			
		Yes, for whom and how long?								
Is retroactive eligibility available?		No				X	No			
		Yes, for whom and how long?								
Does your State Plan contain authority to implement a waiting list?		Not applicable				X	No			
Does your program have a mail-in application?		No								
		Yes				X	Yes			
Does your program have an application on your website that can be printed, completed and mailed in?		No								
		Yes				X	Yes			
Can an applicant apply for your program over phone?		No								
		Yes				X	Yes			
		No								
		Yes – please check all that apply				X	Yes – please check all that apply			
Can an applicant apply for your program on-line?		<input type="checkbox"/> Signature page must be printed and mailed in <input type="checkbox"/> Family documentation must be mailed (i.e., income documentation) <input type="checkbox"/> Electronic signature is required				<input checked="" type="checkbox"/> Signature page must be printed and mailed in <input type="checkbox"/> Family documentation must be mailed (i.e., income documentation) <input type="checkbox"/> Electronic signature is required <input type="checkbox"/> No Signature is required				

	SCHIP Medicaid Expansion Program				Separate Child Health Program			
Does your program require a face-to-face interview during initial application	<div>No</div> <div>Yes</div>				<div>X</div> No			
Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	<div>No</div> <div>Yes</div> <div>Note: this option requires an 1115 waiver</div> <div>Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6</div> <div>specify number of months</div>				<div>X</div> Yes <div>Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6</div> <div>specify number of months</div> <div>4 months for employer sponsored insurance</div>			
Does your program provides period of continuous coverage <u>regardless of income changes?</u>	<div>No</div> <div>Yes</div> <div>specify number of months</div> <div>Explain circumstances when a child would lose eligibility during the time period in the box below</div>				<div>X</div> Yes <div>specify number of months</div> <div>12 months</div> <div>Explain circumstances when a child would lose eligibility during the time period in the box below</div> <div>           1) The family fails to pay SCHIP premiums for 4 consecutive months;            2) The child moves out of state;            3) A SCHIP child becomes Medicaid eligible (e.g., change in family income or family size, or SCHIP child becomes pregnant); or            4) A child reaches his/her 19<sup>th</sup> birthday during the 12-month eligibility period.         </div>			
Does your program require premiums or an enrollment fee?	<div>No</div> <div>Yes</div> <div>Enrollment Fee \$</div> <div>Premium Amount \$</div> <div>Yearly cap</div> <div>Briefly explain fee structure in the box below</div>				<div>X</div> Yes <div>Enrollment Fee \$ None</div> <div>Premium Amount \$ 10 \$</div> <div>Yearly cap</div> <div>Briefly explain fee structure in the box below</div> <div>Premiums are \$10 per month per child, with a maximum of \$30 per month for a family with three or more children.</div>			
Does your program impose copayments or coinsurance?	<div>No</div> <div>Yes</div>				<div>X</div> No			
Does your program require an assets test?	<div>No</div> <div>Yes</div> <div>If Yes, please describe below</div>				<div>X</div> No <div>If Yes, please describe below</div>			

Is a preprinted renewal form sent prior to eligibility expiring?	No	<b>X</b> No
	Yes, we send out form to family with their information precompleted and <input type="checkbox"/> ask for confirmation  <input type="checkbox"/> do not require a response unless income or other circumstances have changed	<input type="checkbox"/> ask for confirmation  <input type="checkbox"/> do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs? ☒ Yes ☐ No
3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? ☒ Yes ☐ No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)				<b>X</b>
b) Application				<b>X</b>
c) Benefit structure				<b>X</b>
d) Cost sharing structure or collection process			<b>X</b>	
e) Crowd out policies				<b>X</b>
f) Delivery system				<b>X</b>
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)				<b>X</b>
h) Eligibility levels / target population				<b>X</b>
i) Eligibility redetermination process				<b>X</b>
j) Enrollment process for health plan selection			<b>X</b>	
k) Family coverage				<b>X</b>
l) Outreach				<b>X</b>
m) Premium assistance				<b>X</b>
n) Waiver populations (funded under title XXI)				<b>X</b>

Parents

Pregnant women

Childless adults



o) Other – please specify

a.

\_\_\_\_\_

b.

\_\_\_\_\_

c.

\_\_\_\_\_



5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing structure or collection process	Effective January 1, 2002, we removed the requirement of a co-pay through an amendment to our Title XXI State Plan. The only cost-sharing requirement we have at this time is a monthly premium.
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
h) Eligibility levels / target population	
i) Eligibility redetermination process	
j) Enrollment process for health plan selection	A SCHIP client living in a mandatory managed care county will be assigned to a managed care plan if they do not voluntarily choose a plan.
k) Family coverage	
l) Outreach	
m) Premium assistance	
n) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
o) Other – please specify	
a.	
b.	
c.	

## SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program.  
 Column 2: List the performance goals for each strategic objective.  
 Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Specify if the strategic objective listed is new/revised or continuing, the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

*Note: If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
To reduce the percentage of uninsured children between 200% and 250% of FPL.	Reduce the percentage of uninsured children between 200% and 250% of FPL.	New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/>
		Data Sources: Washington State Population Survey (WSPS)
		Methodology: Tracking the percentage of uninsured children between 200% and 250% of FPL.
		Progress Summary: The WSPS is a comprehensive survey conducted biennially under contract with Washington State University's Social and Economic Sciences Research Center. The most current survey was conducted in the year 2000, and those results were detailed in the SCHIP 2001 Annual Report. Since the WSPS is conducted biennially, the SCHIP uninsured performance measures will be reported again in 2003.
Objectives Related to SCHIP Enrollment		
To increase the number of children in households between 200% and 250% of FPL who have health insurance coverage.	Increase the number of children between 200% and 250% of FPL who have health care coverage.	New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/>
		Data Sources: Washington State Population Survey (WSPS)
		Methodology: Tracking the number of children in households between 200% and 250% of FPL with health insurance coverage.

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	Reduce the percentage of uninsured children between 200% and 250% of FPL.	<p>Progress Summary: We track the uninsured performance measures using the WSPS. The WSPS is a comprehensive survey conducted biennially under contract with Washington State University's Social and Economic Sciences Research Center. The most current survey was conducted in the year 2000 and those results were detailed in the SCHIP 2001 Annual Report. Since the WSPS is conducted biennially, the SCHIP uninsured performance measures will be reported again in 2003.</p> <p>For SCHIP, it is important to note that there was an increase in the total number of SCHIP enrolled children during the 2001-2002 fiscal year. This data was obtained from our Medicaid Management Information System (MMIS). On September 30, 2001 there were 5,177 children enrolled in SCHIP. On September 30, 2002, our enrolled number had increased to 7,114 children. This is a 37% increase in SCHIP children in FFY 2001/2002.</p>
<b>Objectives Related to Increasing Medicaid Enrollment</b>		
To increase the number of low-income children in households below 200% of FPL who have health insurance coverage.	<p>Increase the number of children below 200% of FPL who have health insurance.</p> <p>Increase the percentage of children below 200% of FPL who have health insurance coverage.</p>	New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/>
		Data Sources: Washington State Population Survey (WSPS)
		Methodology: Tracking the number of children with health insurance in households below 200% FPL.
		<p>Progress Summary: As previously noted, we track the uninsured performance measures using the WSPS. The WSPS is a comprehensive survey conducted biennially under contract with Washington State University's Social and Economic Sciences Research Center. The most current survey was conducted in the year 2000 and those results were detailed in the SCHIP 2001 Annual Report. Since the WSPS is conducted biennially, the SCHIP uninsured performance measures will be reported again in 2003.</p>
<b>Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)</b>		
		New/Revised <input type="checkbox"/> Continuing <input type="checkbox"/>
		Data Sources:
		Methodology:
		Progress Summary:
<b>Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)</b>		
		New/Revised <input type="checkbox"/> Continuing <input type="checkbox"/>

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	Track the satisfaction and health care of SCHIP children compared to Medicaid children and non-Medicaid children.	Data Sources: CAHPS, EPSDT chart review study, HEDIS.
		Methodology:
		Progress Summary: Please see the response to Question #2 below for a detailed summary.
Other Objectives		
		New/Revised <input type="checkbox"/> Continuing <input type="checkbox"/>
		Data Sources:
		Methodology:
		Progress Summary:

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

We measure access primarily through the CAHPS survey using the two composites: 'Getting Needed Care' and 'Getting Care Without Long Waits.' However, other individual questions have relevance to access such as, 'In the last six months, how often did doctors or other health providers spend enough time with your child?'

Washington State had very positive results from the CAHPS SCHIP survey. Our statewide average for the composite 'Getting Needed Care' received 79% for the response "Not a Problem." 'Getting Care Quickly' received 59% for the response "Not a Problem." We also noted that the percentage for "Doctors or Other Health Providers Spending Enough Time with Child" was 69% for the response "Always".

In comparing SCHIP to Washington State Medicaid using CAHPS scores, SCHIP is similar in percentages, with only small differences experienced between SCHIP and/or Medicaid clients. In comparing SCHIP to Healthy Options scores, reported and qualifying well-child care visits for both children and adolescents are slightly higher or comparable to the statewide median for Healthy Options.

Washington submits their SCHIP data to the National CAHPS Benchmarking Database (NCBD). This is the first year NCBD has produced a SCHIP report. First year data will be used as a benchmark in an effort to target improvement areas.

In 2002, MAA conducted an EPSDT chart review study to assess both the quantity and quality of well-child or EPSDT care received by children enrolled in Healthy Options and enrolled or eligible for MAA's SCHIP program. Two age categories were assessed: children 3-6 years of age and adolescents 12-18 years of age. Infants were excluded because only a small number of infants met the enrollment criteria for inclusion. One statewide sample that included both managed care and fee-for-service children was selected. Medical records were examined for the age-appropriate number of well-child care visits, as well as the quality of care. To meet the criteria for a qualifying visit the following information must be documented in the medical record: height, weight, history and physical examination, developmental screen, mental health screen, and one screen for either education or anticipatory guidance.

In the EPSDT study, the report rate for children 3 to 6 years of age was 44%, i.e., of the 3 to 6 year olds in the sample, 44% received one well-child care visit during the review period. For adolescents, the reported rate was 39%, i.e., of the 12 to 18 year olds in the sample, 39% received a well-child visit within a two-year period. The qualifying rate, i.e., those reported visits meeting quality criteria for children was 21% and for adolescents it was 23%. Findings from these studies are fed back to contracted health plans for health plan managed quality improvement efforts and is being used in an MAA-sponsored Quality Improvement project that began in October of 2002.

HEDIS is collected for SCHIP and Medicaid, but the results are not separated by population. At this time, the sample size for SCHIP is too small for meaningful analysis.

Access to care and quality of care is also monitored through our complaints management system, an exemption/disenrollment/fair hearing database, network adequacy standards and on-site managed care contract compliance monitoring and technical assistance.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

Washington State will continue to measure SCHIP using EPSDT and CAHPS. In 2004, MAA plans to survey SCHIP children using the CAHPS survey; in 2005, MAA plans to conduct the EPSDT chart review study and again examine both the quantity and quality of well-child care.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special health care needs or other emerging health care needs? What have you found?

Washington State submitted its CAHPS data to NCDB in 2002 and this included the Children with Chronic Conditions measurement set for SCHIP. NCDB sample size for Children with Chronic Conditions was large enough to draw some conclusions as to their care. Also, the EPSDT study described above in question # 1 above is an example of a focused quality study.

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings.

**Attachment A - CAHPS Report** Summary of findings is detailed in Question #2 above  
**Attachment B - EPSDT Report** Summary of findings is detailed in Question #2 above

## SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

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### ENROLLMENT

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4<sup>th</sup> quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

_____ SCHIP Medicaid Expansion Program (SEDS form 64.21E)	<u>8,754</u>	Separate Child Health Program (SEDS form 21E)
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2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

Washington has used its biennial Washington State Population Survey (WSPS) to make its baseline estimates. We will continue to use this source to measure subsequent changes in the number and percentage of children who have insurance coverage over time. The WSPS is a comprehensive survey conducted under contract with Washington State University's Social and Economic Sciences Research Center. The survey is modeled after U.S. Bureau of the Census's Current Population Survey (CPS). However, the survey is a statewide survey with a greatly enhanced sample size to allow for statistically reliable analyses for the state and regions within the state. There are expanded samples of racial and ethnic minorities to be able to compare socioeconomic characteristics of people of different racial and ethnic backgrounds. Since the WSPS is conducted biennially, the SCHIP performance measures will be reported every two years. The most current survey was conducted in 2000 and the results were reported in our 2001 SCHIP Annual Report.

However, it is important to note that there was an increase in the total number of SCHIP enrolled children during the 2001/2002 fiscal year. This data was obtained from our Medicaid Management Information System (MMIS). On September 30, 2001 there were 5,194 children enrolled in SCHIP. On September 30, 2002, our enrolled number increased to 7,126 children. This is an increase of 37% in FFY 2001/2002.

***(States with only a SCHIP Medicaid Expansion Program, please skip to #4)***

3. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

We do not have a direct count of the effects of the different types of outreach on the number of children enrolled in Medicaid and SCHIP. However, the number of children currently enrolled shows our state's commitment to outreach efforts.

For example, on September 30, 2001 there were 522,314 children in Medicaid and SCHIP medical program categories. As of September 30, 2002, we had 561,789 children in Medicaid and SCHIP medical program categories. This is an increase of 39,475 children, or 7.5%. This data comes directly from our Medicaid Management Information System (MMIS).

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

☒ No, skip to the Outreach subsection, below

☐ Yes, please provide your new baseline ☐ And continue on to question 5

5. On which source does your State currently base its baseline estimate of uninsured children?

☐ The March supplement to the Current Population Survey (CPS)

☐ A State-specific survey

☐ A statistically adjusted CPS

☐ Another appropriate source

A. What was the justification for adopting a different methodology?

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

## OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

We did not change our outreach strategies during this reporting period. We continued to coordinate with our advocates and partners to provide outreach to Medicaid and SCHIP eligible populations.

We also continue to have assistance from the Healthy Kids Now! (HKN!) public awareness campaign that was launched in February 2000 along with the formal SCHIP launch. The HKN! campaign is aimed at families who are eligible for any of the state's children's health programs. They work closely with and directly support existing outreach activities. From October 2001 through September 2002, HKN! took a total of 14,932 calls from families requesting information on children's programs. HKN! does not determine eligibility but provides the caller with an initial screening to determine the likelihood of eligibility. They will then either refer or transfer the caller to a local outreach center, or send them an application.

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The most effective outreach by the state has been to continue supporting community based activities and school involvement in those activities. We also work closely with a statewide outreach coalition of state and local entities. This group meets quarterly and shares best practices and program changes or updates. We partner with the statewide Title 1 Migrant Education Program who in turn partners with school nurses, records clerks, home visitors, and Minorities & Immigrants and Rural populations. Many of these have staff who are bilingual/bicultural to assist clients.

We now have several Community Services Office Call Centers that are able to determine eligibility for children's and pregnancy medical with one phone call (if all necessary information is available). We also have a Statewide Health Insurance Benefits Advisors (SHIBA) helpline that has knowledge of the different medical programs available throughout the state.

We do not have a differentiated count of the effects of the different types of outreach on the number of children enrolled in Medicaid and SCHIP. However, the number of children currently enrolled shows our state's commitment to outreach efforts.

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Washington has learned that the best and most successful way to reach uninsured children is to give meaningful support to community-based efforts. Ideally, that is through funding and operational support. While communities are unique, they welcome the creation of marketing strategies, materials development, and statewide event coordination.

We measure effectiveness by tracking the increase in Medicaid and SCHIP enrollment numbers.

## **SUBSTITUTION OF COVERAGE (CROWD-OUT)**

### ***All States must complete the following 3 questions***

1. Describe how substitution of coverage is monitored and measured.

Crowd-out is monitored through the eligibility process and through data collection. We are careful to prevent crowd-out from occurring at the time of application. First, both the application and the eligibility review form ask a series of questions regarding health insurance status of the applicant's children. If they respond affirmatively to any of the questions, we ask the applicant to list the name of the insurance company or employer providing the insurance. The applicant is ineligible for CHIP if it is determined that they have access to health insurance coverage.

If the applicant does not respond to the questions, they are sent an "Insurance Information Request" letter that they must respond to in order for CHIP eligibility to be determined. If the applicant has access to health insurance coverage, they are not enrolled in CHIP.

Also, at the time of application and redetermination the MMIS is checked to see if there is any history of insurance coverage for the household. If a history shows, further inquiries can be made.

To monitor substitution of coverage, the State tracks responses on the number of applications and eligibility reviews that show the applicant has insurance coverage. In addition, the State tracks the number of applications and eligibility reviews that are denied due to insurance coverage.

The State also tracks whether the applicant has disenrolled from employer-sponsored coverage. If the applicant has lost employer sponsored insurance coverage within the past 4 months, the child must serve a four-month waiting period. However, prior to imposing a waiting period, we look at whether one of nine exceptions applies to the family's situation. Exceptions to the four-month waiting period may be granted when:

- 1) Parent lost job that has medical coverage for children.
- 2) Parent with medical insurance died.
- 3) Child has a medical condition that, without medical care, would cause serious disability, loss of function or death.
- 4) Employer ended medical coverage for children.
- 5) Child's medical coverage ended because the child reached the maximum lifetime coverage amount.
- 6) Coverage under a COBRA extension period ended.
- 7) Children could not get medical services locally (they have to travel to another city or state to get care for their children).
- 8) Domestic violence led to loss of coverage.
- 9) The family's total out-of-pocket maximum for employer sponsored dependent coverage is fifty dollars per month or more.

If none of the exceptions apply, the child must serve a 4-month waiting period prior to enrollment in CHIP.

We do not impose a waiting period on those families who drop private insurance that is not employer related.

Another way we monitor for substitution of coverage is through the review of a monthly report of currently eligible CHIP clients. MAA researches this report for health insurance coverage to ensure there was no substitution of coverage at the time of application or redetermination.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?

Medical Assistance eligibility staff enter application and redetermination information into a database. Data collected during October 2001 through September 2002 showed that approximately 3.6% had dropped employer-sponsored insurance during the prior four months and would potentially be subject to the four-month waiting period. The table below summarizes this data. Non-entered fields as well as data fields for "No Entry" and "Blank" relate to applications/redeterminations that were held for additional information.

Decision Date	Total Applications	Dropped Employer-Sponsored Insurance within last 4 months	Did not drop Employer-Sponsored Insurance	No Entry	Blank
October 2001	195	9	87	0	52
November 2001	177	7	51	6	1
December 2001	147	9	30	2	1
January 2002	193	8	68	12	1
February 2002	160	4	54	4	3
March 2002	269	12	101	4	5
April 2002	239	8	80	1	2
May 2002	213	8	60	9	1
June 2002	205	3	45	2	0
July 2002	261	14	98	4	2
August 2002	300	10	57	5	1
September 2002	235	2	61	1	0
<b>TOTAL</b>	<b>2594</b>	<b>94</b>	<b>792</b>	<b>50</b>	<b>69</b>

3. At the time of application, what percent of applicants are found to have insurance?

On our joint Medicaid/SCHIP application and eligibility review form we ask the question, "Do any of the children you are applying for already have health insurance?" If the client replies "yes," we then require additional details of the insurance coverage. Of the applications/redeterminations deemed to be within SCHIP income guidelines, we found that about 2.5% answer affirmatively to the question on whether the child already has health insurance. The table below details a monthly count from October 2001 – September 2002 of affirmative responses.

Decision Date	Total Applications	Has Health Insurance Coverage at time of Application	No Health Insurance Coverage	Blank	No Entry
October 2001	195	10	95	51	0
November 2001	177	5	120	0	5
December 2001	147	3	102	1	1
January 2002	193	8	168	0	4
February 2002	160	6	131	1	2
March 2002	269	2	218	3	0
April 2002	239	2	151	1	0
May 2002	213	9	122	0	8
June 2002	205	4	138	2	1
July 2002	261	9	172	2	2
August 2002	300	4	217	1	2
September 2002	235	2	201	0	0
<b>TOTAL</b>	<b>2594</b>	<b>64</b>	<b>1835</b>	<b>62</b>	<b>25</b>

**States with separate child health programs over 200% of FPL must complete question 4**

4. Identify your substitution prevention provisions (waiting periods, etc.).

We have a four-month waiting period for those who drop employer-sponsored or job-related coverage. We have exceptions to the waiting period that we review prior to imposing the waiting period. These exceptions are listed in Question #6 below.

**States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.**

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

Prior to determining eligibility for SCHIP, we determine whether the applicant currently has or had job-related insurance within the prior 4-month period. We then look to see whether an exception to the 4-month waiting period applies in their individual case.

**States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)**

6. Identify any exceptions to your waiting period requirement.

We have the following nine exceptions to our requirement of a four-month waiting period:

1. Parent lost job that has medical coverage for children.
2. Parent with medical insurance died.
3. Child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.
4. Employer ended medical coverage for children.
5. Child's medical coverage ended because the client reached the maximum lifetime coverage amount.
6. Coverage under a COBRA extension period expired.

7. Children could not get medical services locally (they have to travel to another city or state to get care).
8. Domestic violence led to loss of coverage.
9. The family's total out-of-pocket maximum for employer sponsored dependent coverage is fifty dollars per month or more.

## **COORDINATION BETWEEN SCHIP AND MEDICAID**

*(This subsection should be completed by States with a Separate Child Health Program)*

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

Yes. Both Medicaid and SCHIP clients are sent an eligibility review form approximately six weeks prior to their 12-month certification ending date. The eligibility review form must be completed and returned prior to the certification ending date.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.

Children on SCHIP and Medicaid are allowed 12 months of continuous eligibility. If a SCHIP child reports a decrease in income during the 12-month period, we will review their eligibility for Medicaid. Our ACES eligibility system allows us to input the new income into the system and the system then automatically changes the child's eligibility status to a Medicaid program if all other Medicaid criteria are met.

For a child with an increase in income that qualifies them for SCHIP rather than Medicaid, the program change does not take affect until their eligibility review month. At the end of the 12 months of eligibility, the current income is reviewed and entered into the eligibility system and the appropriate program is automatically determined.

We have not identified any challenges with this process as our policy of 12 months of continuous eligibility allows the client to report changes without penalty.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain

Yes. The same delivery systems are used in Medicaid and SCHIP. A provider who signs a Core Provider Agreement contract with the Medical Assistance Administration can see both Medicaid and SCHIP clients. The contract with our managed care plans is for both Medicaid and SCHIP. Within the managed care system, providers who are contracted with a participating plan can choose to accept either Medicaid clients, SCHIP clients or both. This managed care system consists of contracts with health carriers for medical care coverage, contracts with Regional Support Networks for mental health care, and fee-for-service (FFS) for primary care case management (PCCM) clinics. Other Medicaid and SCHIP services are "carved out" of managed care and provided on a "wrap-around" FFS basis. These include dental coverage, chemical dependency services, eyeglasses, hearing aid devices, pregnancy terminations, and non-emergent transportation.

## ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply.*

- ☐ Follow-up by caseworkers/outreach workers
- ☐ Renewal reminder notices to all families, *specify how many notices and when notified* \_\_\_\_\_
- ☐ Targeted mailing to selected populations, *specify population* \_\_\_\_\_
- ☐ Information campaigns
- ☐ Simplification of re-enrollment process, *please describe* \_\_\_\_\_
- ☒ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe:*
- We conducted a survey of disenrolled clients in the fall of 2001 to determine why they disenrolled. We mailed out 793 surveys, and had a 12% response rate. The most common response as to why a client disenrolled was that they had acquired other insurance (60%). We plan to continue to survey disenrolled clients as our budget situation allows.
- ☒ Other, *please explain* \_\_\_\_\_

Once enrolled, a child remains eligible for twelve consecutive months, regardless of income changes. At the tenth month of enrollment, the client is sent an eligibility review form to complete and return so that eligibility for another twelve months can be redetermined before the current twelve-month period expires.

We also notify clients who fall behind in their premium payments once their premium payment has become 90 and 120 days overdue. Both the 90 and 120 day notices give the client a toll-free number to call and report if their income has changed or there are other circumstances they need to report.

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

Information from the survey of disenrolled clients will assist us in identifying any barriers to retention of SCHIP children. Also, the six-week time period for renewing eligibility prior to the end of the client's certification period allows the client time to gather necessary information so that they will not be disenrolled.

We recently began tracking the reasons why clients disenroll from SCHIP through our ACES eligibility system. This data will be used to determine how and why clients fail to renew at their twelve-month review.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?). If so, describe the data source and method used to derive this information.

We recently had our ACES contractor create a monthly report that shows the number of children who disenroll each month along with a corresponding reason code that relates to the specific disenrollment reason. When a child is disenrolled from SCHIP, our eligibility system requires a reason code be entered. This information is captured monthly by each reason code and compiled into a report. We track these same children both one month and six months after disenrollment to see whether they have reenrolled in either SCHIP or another medical assistance program. Additionally, we receive data with household information for those children who do not have a specific reason code upon disenrollment so that we can contact them for more information on why they disenrolled.

**Attachment C** contains a detailed report showing the number of children disenrolled by reason code for the initial six months of this report. In summary, the most common categories of disenrollment were the

failure to provide necessary documentation for eligibility determination, aging out of the program, and being eligible for another medical program.

Prior to implementation of our ACES report, we conducted a survey of disenrolled clients in the fall of 2001 to determine why children disenrolled. We sent out 793 surveys, and had a 12% response rate. The most common response as to why a client disenrolled was that they had acquired other insurance (60%). We plan to continue to survey disenrolled clients as our budget situation allows.

## **COST SHARING**

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

At this time, we have not yet undertaken an assessment of the effects of premiums on participation in SCHIP in our state.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

We have not yet undertaken an assessment of the effects of cost sharing on utilization of health services in SCHIP.

## **FAMILY COVERAGE PROGRAM UNDER TITLE XXI**

1. Does your State offer family coverage through a family coverage waiver as described in 42 CFR §457.1010?

\_\_\_\_\_ Yes, briefly describe program below  
and continue on to question 2.

  X   No, skip to the Premium Assistance Subsection.

2. Identify the total State expenditures for family coverage during the reporting period.
3. Identify the total number of children and adults covered by family coverage during the reporting period. (Note: If adults are covered incidentally they should not be included in this data.)  
\_\_\_\_\_ Number of adults ever enrolled during the reporting period  
\_\_\_\_\_ Number of children ever enrolled during the reporting period
4. What do you estimate is the impact of family coverage on enrollment, retention, and access to care of children?
5. How do you monitor cost effectiveness of coverage? What have you found?

## **PREMIUM ASSISTANCE PROGRAM UNDER SCHIP STATE PLAN**

1. Does your State offer a premium assistance program through SCHIP?

Note: States with family coverage waivers that use premium assistance should complete the Family Coverage Program subsection. States that do not have a family coverage waiver and that offer premium assistance, as part of the approved SCHIP State Plan should complete this subsection and not the previous subsection.

\_\_\_\_\_ Yes, briefly describe your program below and  
continue on to question 2.

  X   No, skip to Section IV.

2. What benefit package does your state use? e.g., benchmark, benchmark equivalent, or secretary approved
3. Does your state provide wrap-around coverage for benefits?
4. Identify the total number of children and adults enrolled in your premium assistance SCHIP program during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).  
  
\_\_\_\_\_ Number of adults ever enrolled during the reporting period  
\_\_\_\_\_ Number of children ever enrolled during the reporting period
5. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program.
6. Indicate the effect of your premium assistance program on access to coverage.
7. What do you estimate is the impact of premium assistance on enrollment and retention of children?

## SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. *Note: This reporting period = Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02). If you have a combination program you need only submit one budget; programs do not need to be reported separately.*

### COST OF APPROVED SCHIP PLAN

Benefit Costs	Reporting Period	Next Fiscal Year	Following Fiscal Year
Insurance payments			
Managed Care	4,665,247	6,280,203	8,401,775
Per member/Per month rate @ # of eligibles	\$73.76	\$73.48	\$80.00
Fee for Service	3,592,812	4,670,120	5,763,831
<b>Total Benefit Costs</b>	<b>8,258,059</b>	<b>10,950,323</b>	<b>14,165,606</b>
(Offsetting beneficiary cost sharing payments)	336,027	492,754	605,541
<b>Net Benefit Costs</b>	<b>\$7,922,032</b>	<b>\$10,457,569</b>	<b>\$13,560,065</b>

### Administration Costs

Personnel	134,818	105,000	105,000
General Administration	91,529	600,000	600,000
Contractors/Brokers (e.g., enrollment contractors)	41,067		
Claims Processing	4,890	3,500	3,500
Outreach/Marketing costs*	1,312,777	100,000	100,000
Other			
<b>Total Administration Costs</b>	<b>1,585,081</b>	<b>808,500</b>	<b>808,500</b>
<b>10% Administrative Cap</b> (net benefit costs ÷ 9)	<b>880,225</b>	<b>1,161,952</b>	<b>1,506,674</b>

<b>Federal Title XXI Share</b>	<b>6,179,623</b>	<b>7,322,945</b>	<b>9,339,567</b>
<b>State Share</b>	<b>3,327,490</b>	<b>3,943,124</b>	<b>5,028,998</b>

<b>TOTAL COSTS OF APPROVED SCHIP PLAN</b>	<b>9,507,113</b>	<b>11,266,069</b>	<b>14,368,565</b>
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2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☐ Other (specify)

\*Note: \$2,974,498 of Outreach Expenditures during FFY01/02 were not subject to 10% Admin. ceiling, therefore, none of the Outreach expenditures claimed during FFY02 were subject to the lid.

## SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled your demonstration SCHIP program during the reporting period.

\_\_\_\_\_ Number of **children** ever enrolled during the reporting period in the demonstration

\_\_\_\_\_ Number of **parents** ever enrolled during the reporting period in the demonstration

\_\_\_\_\_ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

\_\_\_\_\_ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration waiver is on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. *Note: This reporting period (Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	Reporting Period	Next Fiscal Year	Following Fiscal Year
<b>Benefit Costs for Demonstration Population #1 (e.g., children)</b>			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
<b>Total Benefit Costs for Waiver Population #1</b>			
<b>Benefit Costs for Demonstration Population #2 (e.g., parents)</b>			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
<b>Total Benefit Costs for Waiver Population #2</b>			
<b>Benefit Costs for Demonstration Population #3 (e.g., pregnant women)</b>			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
<b>Total Benefit Costs for Waiver Population #3</b>			
<b>Total Benefit Costs</b>			
(Offsetting Beneficiary Cost Sharing Payments)			
<b>Net Benefit Costs</b> (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			
<b>Administration Costs</b>			
Personnel			
General Administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other (specify)			
<b>Total Administration Costs</b>			
<b>10% Administrative Cap</b> (net benefit costs ÷ 9)			
<b>Federal Title XXI Share</b>			
<b>State Share</b>			
<b>TOTAL COSTS OF DEMONSTRATION</b>			

## **SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS**

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1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

Washington State, as well as many other states, is going through a challenging time for healthcare. Healthcare costs have risen dramatically as state revenues have decreased. Our fiscal situation has led to fewer providers accepting new Medicaid and SCHIP children. Our policy administrators and lawmakers are currently focused on how to keep as many services as possible while working within the revenue we have available. We anticipate the upcoming year will continue to be very challenging.

2. During the reporting period, what has been the greatest challenge your program has experienced?

The greatest challenges have been the current economic/budget environment and the inability to fully utilize appropriated funds.

3. During the reporting period, what accomplishments have been achieved in your program?

One of our accomplishments is that we have continued to increase our enrollment into the program. SCHIP enrollment increased from 5,177 children on September 30, 2001, to 7,114 on September 30, 2002 – a 37% increase.

In spite of our fiscal challenges, we continue to have strong support from advocacy groups and community members who provide outreach to potential SCHIP clients.

We have also continued to increase our data collection ability. We now have a greater picture of who our clients are as we collect data on household income levels, age, race, primary language and reasons for disenrollment.

In July of 2002, CMS conducted a SCHIP review of Washington State with very positive results. The written report from CMS is expected to be available soon.